# Grand Canyon Counseling

**PATIENT INFORMATION**

Name: ______________________________ Cell Phone: ______________

Address: ______________________________ Work Phone: ______________

City: ________________ State: _______ Zip: ______ Other Phone: ______________

Date of Birth: ___/___/___ Gender: __ M __ F Email: ______________________

____Child ____ Single Adult ____Married ____Other Explain: ________________

Employer and/or School: ______________________ ___Employed ___Student

*Referred by:* ______________________________________________

**RESPONSIBLE PARTY – if different from above** – (Parent, etc.) Relationship to patient: _______

Name: ______________________________ Cell Phone: ______________

Address: ______________________________ Work Phone: ______________

City: ________________ State: _________ Zip: ________ Other Phone: ______________

Date of Birth: ___/___/___ Gender: __ M __ F Email: ______________________

____Child ____ Single Adult ____Married ____Other Explain: ________________

Employer and/or School: ______________________ ___Employed ___Student

**OTHER BILLING INFORMATION** (Complete only if someone other than the patient or parent is to be billed):

Name: ______________________________ Cell Phone: ______________

Address: ______________________________ Work Phone: ______________

City: ________________ State: _______ Zip: ______ Other Phone: ______________

Relationship to Patient: ______________________________________________

**HOME /FAMILY INFORMATION** (List all persons living in the home of the patient.)

| NAME | DATE OF BIRTH | RELATIONSHIP |
|---|---|---|
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**Please go over this information carefully and feel free to ask any questions you may have. Signing this agreement is necessary to initiate assistance at Grand Canyon Counseling. This information represents a contract between the therapist and the patient.**

**Limits of service and Assumption of Risk:** Psychotherapy and counseling are both essentially relationships between the patient and the therapist. Unlike visiting a medical doctor, psychotherapy requires an active effort on the part of the patient and family. Therapy offers support and sets the atmosphere to foster the patient's desired changes. There are both benefits and risks related to therapy. The benefits are your desired changes and improvements. The risks include awareness of negative feelings such as sadness, guilt, anxiety, anger, and frustration, or the patient may not be able to make all the changes desired. There are no guarantees that counseling or psychotherapy will produce constructive changes. Initial meetings are evaluative, and your personal goals for therapy should be stated and explored. If you have any questions about therapist technique, please ask.

**Professional Records:** Both law and the standards of the therapy professions require that appropriate treatment records are kept. You are entitled to view the records, unless your therapist determines that seeing them would be emotionally damaging. In that case you can have another therapist of your choice review the records for you. Patients may be charged for review time, copies, or mailings of records.

**Session and Fee Information:** Counseling/psychotherapy sessions are typically 45 – 50 minutes long, leaving 10 – 15 minutes between the hours to write notes regarding the case. You are to pay at the time of service for the full amount of the session. Payment is the responsibility of the patient (or parents if the patient is a minor). If payments are not paid as agreed, the responsible party's account information may be turned over to a collection agency.

**Time, Scheduling, Cancellation of Appointments:** Your therapist is usually able to begin promptly at the scheduled time. If the session must begin late because of the therapist's schedule, the session will still be for the full session length. If you arrive late it will still be necessary for the session to end at the regular time. The charge to you for the shortened session will be for the full amount of a regular session. You will not be charged for a session if you let the therapist know at least twelve (12) hours in advance. You will be charged the Full Regular Fee if you fail to keep a scheduled appointment and do not notify the therapist twelve (12) hours in advance. Continuity in session topics is important, the intent is to maintain a fair working relationship.

**Insurance and Method of Payment:** Insurance may help to pay for charges of the sessions. Some insurance companies do not provide coverage for mental health. If requested a form will be completed by Grand Canyon Counseling that you can provide to your insurance carrier to seek reimbursement. Reimbursement will be paid directly to you. Whether or not your insurance plan covers services provided, you are responsible for fees for all services provided. You may pay by cash, check, money order, or credit card.

**Limits of Confidentiality:** What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. There are some exceptions to the principle of confidentiality:

**Duty to Warn and Protect**
If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

**Abuse of children and Vulnerable Adults**
If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

**Prenatal Exposure to Controlled Substances**
Therapist must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

**Minors/Guardianship**
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

**Insurance Providers**
Insurance companies and other third-party payers are given information that they request regarding services to the clients.

The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

**Patients Rights:** I (We) understand that patients have basic rights, including:

1. The right to be informed of the various steps and activities of treatment.
2. The right to confidentiality under federal, state, and HIPPA laws related to counseling.
3. The right to humane care and protection from harm, abuse, or neglect.
4. The right to make an informed decision whether to accept or refuse treatment.
5. The right to consult with counsel or other practitioner at my (our) expense.

**Informed Consent contract:**
The services for________________________ at Grand Canyon Counseling Services will cost ________ per session. Fees are subject to change with a 30 day notice. The primary therapist in this case is to be Ron E. Paterik, L.I.S.A.C. I (We) have read this agreement document, have assisted in completing financial agreement section of the document, understand the nature of services to be provided, and agree with the terms of the document. I (We) accept responsibility to pay the fees at the time the services are provided. I (We) have chosen to receive counseling services at Grand Canyon Counseling. The choice is voluntary, and services can be terminated at any time. The therapist works for the patient's best interest, and is directed by the needs of the patient as well as by professional and ethical guidelines. While the therapist may help define goals and discuss possible alternatives for reaching them, the patient or patient's family maintain personal responsibility for all decisions. By signing below, I agree to the above assumption of risk and limits of confidentiality and services.

SIGNED: __________________________________________________ DATE: _________________

Adult Patient or Parent of Child Patient